North Central Region EMS &
Trauma Care Council

Patient Care Procedure
Dispatch of Agencies

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To provide timely & appropriate care to all emergency medical & trauma patients as identified in WAC 246-976-390.
2. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
3. To establish uniform & appropriate dispatch of response agencies.
4. To utilize Criteria Based EMD trained dispatchers to identify potential Major Trauma incidents & activate the Trauma System by dispatching the appropriate services.

II. STANDARDS:

1. Licensed aid and/or licensed ambulance services shall be dispatched by trained dispatchers to all emergency medical incidents.
2. Verified aid and/or verified ambulance services shall be dispatched by trained dispatchers to all known injury incidents, which meet Trauma Registry Inclusion Criteria.
3. All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.

III. PROCEDURE:

1. The nearest appropriate aid and/or ambulance service shall be dispatched per the above standards as identified in the North Central Regional EMS/Trauma Care response area maps, or as defined in local and/or county operating procedures.

IV. DEFINITION:

1. Per WAC 246-976-010, "response time" is defined as "the time from agency notification until the time the first EMS personnel arrive at the scene."
2. "Appropriate" is defined as "the verified or licensed service that normally responds within an identified service area."

V. QUALITY IMPROVEMENT

The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

North Central Region EMS &
Trauma Care Council

Patient Care Procedure
Response Times

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To define prehospital response times for emergency medical & trauma incidents to urban, suburban, rural and wilderness areas in the North Central Region.
2. To define urban, suburban, rural and wilderness response areas.
3. To provide trauma patients with appropriate & timely care.

II. STANDARDS:

1. All verified ambulance & aid services shall respond to emergency medical & trauma incidents in a timely manner in accordance with WAC 246-976-390.
2. All licensed ambulance & aid services shall respond to emergency medical incidents in a timely manner.

III. PROCEDURE:

1. The Regional Council, with input from prehospital providers and Local Councils, shall identify response areas & times as urban, suburban, rural and wilderness.
2. Verified/licensed ambulance & verified/licensed aid services shall collect & submit documentation to ensure the following response times are met or exceeded as established by PCP, COP or WAC 246-976-390 & 430.

Aid Vehicle		Ambulance	
Urban	8 minutes	Urban	10 minutes
Suburban	15 minutes	Suburban	20 minutes
Rural	45 minutes	Rural	45 minutes
Wilderness	ASAP	Wilderness	ASAP

3. Verified aid & ambulance services shall provide documentation on major trauma cases to show the above response times are met 80% of the time.
4. County Operating Procedures must meet or exceed the above standards.
5. Verified/licensed ambulance & verified/licensed aid are encouraged to set the “Golden Hour” as a goal for wilderness response times.

IV. DEFINITION:

1. An agency response area or portion thereof:

a. **Urban** - an incorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 & a population density over 2,000 per square mile.

b. **Suburban** – an incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.

c. **Rural** - an incorporated or unincorporated area with total populations less than 10,000 or with a population density of less than 1,000 per square mile.

d. **Wilderness** - any rural area not readily accessible by public or private road.

2. **Agency response time** is defined as the time from agency notification until the time the first EMS personnel arrive at the scene. (This is defined in WAC and constitutes "activation time" plus "enroute time.")

V. QUALITY IMPROVEMENT:

1. The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

North Central Region EMS &
Trauma Care Council

Patient Care Procedure
Timely & Appropriate EMS Response

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To ensure that emergency medical & trauma patients who live in an area that is serviced by two or more ambulance providers, which have the same level of licensure, receive the timeliest & highest level of care that is available.

II. STANDARDS:

1. If available, the highest-level "appropriately staffed" ambulance within a designated area shall be dispatched to emergency medical & trauma incidents.

III. PROCEDURE:

1. Except when "extraordinary circumstances" exist, the highest level "appropriately staffed" licensed ambulance shall respond to all emergency medical & trauma incidents.
2. When a licensed ambulance provider is unable to immediately respond an "appropriately staffed" ambulance to an emergency medical or trauma incident, and there exists another ambulance which is "appropriately staffed" and capable of responding to the incident in a timely manner, then the service that was originally dispatched shall transfer the call to the second ambulance for response.
3. This procedure shall only apply to emergency calls received through the county 911-dispatch center.

IV. DEFINITION:

1. **Extraordinary Circumstances** shall be defined as situations out of the usual when all available ambulances from local licensed ambulance providers are committed to calls for service.
2. **Appropriately Staffed** shall be defined as an ambulance which immediately initiates it's response to an emergency medical or trauma incident staffed with at least two crew members which are certified to a level that is commensurate with the standard of care that has been set in the local area. (i.e., Paramedic/EMT, ILS-EMT/EMT, EMT/EMT or EMT/1st Responder)
3. **Highest Level** shall be defined as the service within the response area that has the highest level of certified personnel available, at the time of the call.

V. QUALITY IMPROVEMENT:

1. The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

North Central Region EMS &
Trauma Care Council

Patient Care Procedure
Helicopter Response

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE:

1. To define who may initiate the request for on-scene emergency air medical services, and under what circumstances non-medical personnel may request on-scene air medical services.
2. To institute a program of continuous evaluation to determine the best utilization of air medical services in our region.

II. STANDARDS:

1. Early activation of air ambulance services should be initiated as soon as the medical condition of the patient and scene location/conditions would favor, by at least 10 minutes, air transport of the major trauma or critical medical patient.

III. PROCEDURE:

1. Air ambulance services should be used when it will reduce total out of hospital time for a major trauma patient by 10 minutes or more.
2. Air ambulance services may be used for medical and non-major trauma patients under special circumstance and only with clearance by medical control.
3. Prehospital personnel en route to the scene should make the request to place an air ambulance service on standby, or initiate a request for an on-scene response.
4. The call must be initiated through the appropriate medical emergency dispatching agency.
5. The helicopter communications staff will always give an approximate launch time, flight time and advise when lifted to the dispatchers requesting services.
6. The responding helicopter will make radio contact with the receiving hospital at, or shortly after liftoff from the scene.
7. An air ambulance that has been launched or placed on standby can only be cancelled by the highest level of transporting prehospital personnel dispatched to the scene.

IV. DEFINITION:

1. **Standby:** Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from the standby.
2. **Launch Time:** Launch time is the time the skids lift the helipad en route to the scene location.

V. QUALITY IMPROVEMENT:

1. A regional helicopter response report form for each flight or standby request, including cancelled flights, must be submitted to the QI Committee at the end of each calendar quarter. These will be reviewed, with local input, to develop a definition of the most appropriate circumstances for helicopter requests.

North Central Region EMS &
Trauma Care Council

Patient Care Procedure
IDENTIFICATION OF MAJOR TRAUMA & EMERGENCY MEDICAL PATIENTS

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedures.

2. To ensure that all emergency medical patients are transported to the closest most appropriate facility in the shortest time possible.

3. To ensure that all major trauma patients are transported to the most appropriate facility capable of meeting the patient's need in accordance with WAC 246-976-370.

4. To allow the designated facility sufficient time to activate their emergency medical and/or trauma resuscitation team. (See WAC 246-976-550 (d).

II. STANDARDS:

1. Major trauma patients will be identified in the initial EMS field assessment using the most current State of Washington Prehospital Trauma Triage (Destination) Procedures as published by the Department of Health.

2. Major trauma patients will be identified by the region's prehospital services and hospitals for the purposes of state trauma registry inclusion using the trauma registry inclusion criteria as outlined in
WAC 246-976-430.

3. Major trauma patients will be identified for the purposes of regional quality improvement as patients who meet the Trauma System Activation criteria of the most current version of the State of Washington Prehospital Triage Procedures, and patients who activate hospital resource teams and those who meet the hospital trauma patient registry criteria.

4. Patients not meeting the criteria to activate the trauma system will be transported to the closest most appropriate local facility as outlined in local procedures.

III. PROCEDURE:

1. The first certified EMS/TC provider to determine that a patient:
   a. Meets the trauma triage criteria and/or
   b. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)
   c. Needs definitive medical care should contact the nearest appropriate highest designated facility via the H.E.A.R. frequency (or other means as conditions dictate).

2. Radio contact with the receiving facility should be preceded with the phrase: "This is a major trauma or major heart alert."

3. The receiving facility shall be provided with the following information, as outlined in the Prehospital Destination Tool:

   a. Identification of EMS agency.
   b. Patient's age.
   c. Patient's chief complaint or problem.
   d. If injury, identification of the biomechanics and anatomy of the injury.
   e. Vital signs.
   f. Level of consciousness.
   g. Other factors that require consultation with medical control.
   h. Number of patients (if more than one).
   i. Amount of time it would take to transport the patient form scene to the nearest appropriate hospital (transport time).

4. When determined that a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist or ankle as soon as appropriate.

5. Whenever possible, ILS or ALS service should be dispatched to the scene by ground or air as appropriate. <u>If unavailable, rendezvous will be arranged with the highest possible level of care.</u>

6. While enroute to the receiving facility, the transporting agency shall provide complete report to the receiving hospital regarding the patient's status.

7. All information shall be documented on an appropriate medical incident report (MIR) form approved by the county medical program director.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To ensure that trauma patients receive treatment in facilities that have made a commitment to the provision of designated trauma service.

2. To define the referral resources for inter-facility transfers of patients requiring a higher level of care or transfer due to situational inability to provide care.

3. To recommend criteria for inter-facility transfer of major trauma patients from receiving facility to a higher level of care:

II. STANDARDS:

1. Written transfer agreements will be in place among all facilities in the region and tertiary care facilities commonly referred to which are out of the region.

2. All interfacility transfers shall be in compliance with current OBRA/COBRA regulations and consistent with RCW 70.170.060(02).

3. Level IV and V facilities will transfer the following adult and pediatric patients to level I or II facilities for post resuscitation care:

Central Nervous System Injury Dx
Head injury with any one of the following:
- Open, penetrating, or depressed skull fracture
- Severe coma (Glasgow Coma Score <10)
- Deterioration in Coma Score of 2 or more points
- Lateralizing signs

Unstable spine
Spinal cord injury (any level)
Chest Injury Dx
Suspected great vessel or cardiac injuries
Major chest wall injury
Patients who may require protracted ventilation
Pelvis Injury Dx
Pelvic ring disruption with shock requiring more than 5 units of blood transfusion
Evidence of continued hemorrhage
Compounded/open pelvic fracture or pelvic visceral injury
Multiple System Injury Dx
Severe facial injury with head injury
- Chest injury with head injury
- Abdominal or pelvic injury with head injury
- Burns with head injury

Specialized Problems
- Burns > 20% BSA or involving airway
- Carbon monoxide poisoning
- Barotrauma

Secondary Deterioration (Late Sequelae)
- Patients requiring mechanical ventilation
- Sepsis

Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation systems)

4. All pediatric patients less than 15 years who are triage under Step I or II of the Prehospital triage tool, or are unstable after ED resuscitation or emergent observation intervention at hospital with general designations should be considered for immediate transfer to a level I designated pediatric trauma center.

5. For inter-facility transfer of critical major trauma patients, air or ground ALS transport is the standard. Trauma verified services shall be used for all inter-facility transfers of major trauma patients.

6. Transport of patients out of region shall be consistent with these standards.

III. PROCEDURE:

1. The General and Pediatric Trauma Transfer Criteria established by the Department of Health should be followed. Each designated trauma facility is required to develop procedures, protocols, and criteria defining which patients they keep or transfer.

2. The transferring facility must make arrangements for the appropriate level of care during transport.

3. The receiving facility must accept the transfer prior to the patient leaving the sending facility.

4. The receiving physician must accept the transfer prior to the patient leaving the sending facility.

5. All appropriate documentation must accompany the patient to the receiving facility.

6. The transferring physician's order shall be followed during transport as allowed by MPD protocols. Should the patient's condition change during transport, the transferring/sending physician, if readily available, should be contacted for further orders.

7. The receiving facility will be given the following information:

    a. Brief history
    b. Pertinent physical findings
    c. Summary of treatment
    d. Response to therapy and current condition

8. Further orders to transport personnel may be given by the receiving physician.

9. MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.

10. Level IV and V trauma facilities should consider having trauma patients transferred by either ground or air according to the facility's interfacility transport plan.

11. Air transport should be considered for interfacility transfer in the North Central Region when transport by ground will be greater than 30 minutes.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

North Central Region EMS &
Trauma Care Council

Patient Care Procedure
DESIGNATED TRAUMA CENTER DIVERSION

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To define implications for initiation of trauma center diversion (bypass) status in the Region.
2. To define the methods for notification of initiation of trauma center diversion.
3. To identify situations when a facility must consider diverting major trauma patients to another designated trauma center.

II. STANDARDS:

1. Designated trauma centers in the North Central Region will go on diversion for receiving major trauma patients based on the facilities' ability to provide initial resuscitation, diagnostic procedures, and operative intervention at the designated level of care.

2. Diversion will be categorized as partial or total based on the inability of the facility to manage specific types of major trauma or all major traumas at the time.

   Hospitals must consider diversion when:
   - Surgeon is unavailable
   - OR is unavailable
   - CT is down if Level II
   - ER unable to manage more major trauma
   - Beds are unavailable
   - Shortage of needed staff

3. Each designated trauma center will have a hospital approved policy to divert patient to other designated facilities on the ability to manage each patient at a particular time. A diversion log will be kept indicating the time of diversion and the reason for partial or total diversion.

4. All facilities initiating diversion must provide notification to other designated trauma centers in Region.

III. PROCEDURE:

1. Trauma centers will consider diverting major trauma patients based on the above standards.

2. A designated trauma center on partial or total diversion shall notify other designated trauma centers in the Region.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

Grant County EMS &
Trauma Care Council

County Operating Procedures

Procedure #1-Tiered Response Rendezvous

Adopted by Grant County Council:
Recommended by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

Purpose:

The Grant County Local Council encourages tiered response within the county. A tiered response system shall be used to provide an appropriate higher level of care anywhere in Grant County such care is readily available. Recognizing that there are areas where a tiered response is not appropriate because of time and distance, a rendezvous with an appropriate higher level of care will be requested, per Grant County EMS Protocols, anywhere in Grant County such a rendezvous is readily available.

Procedure for Tiered Response:

1. The nearest appropriately trained personnel and/or agency shall be dispatched as the primary ambulance.
2. If the severity of the incident is known and indicates the necessity of higher level of care, the dispatchers should also dispatch the next level of care immediately in those areas where the Grant County Local Council has identified a tiered response.
3. If the severity of the incident is unknown, the primary ambulance shall advise dispatchers to dispatch the next level of care as outlined in the Grant County Protocols. The primary ambulance will not delay transport to wait for the higher level of care, but will rendezvous instead.
4. When both agencies are on scene, the higher level personnel will assume care of the patient, and determine which ambulance transports.

Procedure for Rendezvous:

1. In areas where no tiered response has been identified, agencies should request a rendezvous with a higher level of care as outlined in the Grant County Protocols, if such care is readily available.
2. No agency, including ILS and ALS agencies, should delay transport of any patient to perform advanced skills that can be performed en route to the hospital.
3. When two agencies rendezvous, the higher level of care shall board the primary ambulance and assume responsibility for the care of the patient.

Quality Assurance:

The Grant County Quality Assurance Committee will analyze and make necessary changes in this procedure as may be indicated.

Greater Wenatchee EMS &
Trauma Care Council

County Operating Procedures
Procedure #1-ALS Response on U.S. 97
Douglas County

Adopted by Greater Wenatchee Council: May 15, 1996
Recommended by Regional Council: 1996
Approved by DOH: 1996
Revised:

Purpose:

1. To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents on U.S. 97 in Douglas County in the area between Sun Cove Estates and Twin W Orchards (milepost 224 to milepost 27).
2. To provide timely and appropriate care to all emergency medical and trauma patients.
3. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of ALS response agencies.

Standard:

1. An ALS agency from Chelan shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned stretch of U.S. 97 in Douglas County.
2. All major trauma patients on this stretch of U.S. 97 shall be automatically transported to highest-level designated trauma center.
3. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate.

Procedure:

1. Waterville Ambulance shall be dispatched to all major trauma incidents on U. S. 97 to milepost 227. If ALS (paramedic) certified personnel are part of the response team, the dispatch center shall be so notified.
2. When the location of the emergency medical or major trauma incident is south of milepost 224 (entrance to Sun Cove Estates), an ALS agency out of Wenatchee shall be automatically dispatched to the scene.
3. When the location of the emergency medical or major trauma incident is north of milepost 224, the ALS agency out of Chelan shall be automatically dispatched to the scene.
4. All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
5. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

Quality Improvement:

The Regional Quality Improvement Committee shall develop written plan for implementation to address issues of compliance with the above standards and procedures.

Adopted by Greater Wenatchee County Council: May 15, 1996
Recommended by Regional Council: 1996
Approved by DOH: 1996
Revised:

Purpose:

1. To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents in the Douglas County Fire District #4 service area currently served by Waterville Ambulance (milepost 138 to milepost 142.5 on U.S. 2, and milepost 213 north to milepost 224 on U.S. 97.
2. To provide timely and appropriate care to all emergency medical and trauma patients
3. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of ALS response agencies.

Standard:

1. An ALS agency from Wenatchee shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned areas in Douglas County.
2. All major trauma patients on the above-mentioned areas of Douglas County shall be automatically transported to highest-level designated trauma center.
3. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate.

Procedure:

1. Waterville Ambulance shall be dispatched to all major trauma incidents in the above-mentioned area. If ALS (paramedic) certified personnel are part of the response team, the dispatch center shall be so notified.
2. An ALS agency out of Wenatchee shall automatically be dispatched to all emergency medical and major trauma incidents in the above-mentioned area.
3. All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
4. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

Quality Improvement:

The Regional Quality Improvement Committee shall develop written plan for implementation to address issues of compliance with the above standards and procedures.